No. 79-1380

MICHAEL ROD

IN THE

Supreme Court of the United States

October Term, 1980

PATRICIA R. HARRIS,
Secretary of Health and Human Services,
Appellant,

v.

CHARLES EDWARD WILSON, et al.,
Appellees.

On Appeal From the United States District Court for the Northern District of Illinois

BRIEF OF AMICUS CURIAE THE NATIONAL ASSOCIATION FOR MENTAL HEALTH THE AMERICAN PSYCHIATRIC ASSOCIATION THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

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PATRICIA R. HARRIS
Secretary of Health and Human Services,
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ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

BRIEF OF AMICUS CURIAE

INTEREST OF THE AMICI CURIAE

The Amici Curiae are three national organizations with a direct interest in the welfare of the institutionalized mentally disabled. The National Association for Mental Health is a voluntary citizens' organization with approximately one million members, whose purposes include working for the promotion of mental health and the improvement of services for the mentally impaired. The American Orthopsychiatric Association is an interdisciplinary association of psychiatrists, psychologists, social workers, educators, and allied health professionals whose four thousand members are concerned with the problems of those who suffer from mental disorder. The American Psychiatric Association is a membership organization of over twenty-five thousand psychiatrists, many of whom treat and care for the indigent publicly institutionalized mental patients in our nation. Each of these associations is concerned with the promotion of individual dignity and the rehabilitation of the publicly institutionalized mental patient.

Amici file this brief pursuant to consents of the parties which have been filed with the Clerk of Court.

SUMMARY OF ARGUMENT

This class action deals with the total exclusion of certain publicly institutionalized mental patients from need-based Supplemental Security Income benefits (hereinafter "SSI") under Section 1611(e)(1)(B) of the Social Security Act, 42 U. S. C. § 1382(e)(1)(B). The question before this Court on appeal is whether the statutory exclusion from benefits under 42 U. S. C. § 1382(e)(1)(B) violates the Due Process Clause of the Fifth Amendment to the United States Constitution.

In this Amicus Brief, the National Association for Mental Health, the American Orthopsychiatric Association, and the American Psychiatric Association will deal with the vitally important nature of the benefits in question to the institutionalized indigent individuals affected. Amici here assert that the statutory classification in 42 U. S. C. § 1382(e)(1)(B) violates the Due Process Clause of the Fifth Amendment to the United States Constitution in that the statute fails to meet scrutiny under traditional rational basis standards.

ARGUMENT

I. The Personal Need Allowance in 42 U. S. C. § 1382 (e)(1)(B) Is Vitally Necessary to Indigent Institutionalized Residents' Dignified Subsistence and Rehabilitation

A. A Personal Need Allowance Is Necessary to a Humane and Dignified Subsistence Within the Institution.

Historically, the movement for special institutions for the insane began in the first quarter of the nineteenth century. A. DEUTSCH, THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES 112 (1967). That movement was followed in the second quarter of the nineteenth century by the rise of the state institution. *Id.* at 133.[1] Though the modern trend has been toward the reintegration of the mentally ill into the community, *see, e.g.*, Greenblatt and Glazer, *The Phasing Out of Mental Hospitals in the United States*, 132 AM. J. PSYCHIATRY 1135 (1975); Community Mental Health Centers Act, 77 Stat. 290, *as amended*, 42 U. S. C. §§ 2689 *et seq.* (Supp.), of the 600,000 mentally ill individuals who receive active treatment in this country each year, nearly 200,000 remain hospitalized in public institutions.[2] 1 FINAL REPORT TO THE PRESIDENT FROM THE

1. By that time old notions concerning the mentally ill as incurable had been discarded and reformers such as Dorothea Dix lobbied for a rebuilding of our system of care for the disabled mentally ill. DEUTSCH, *supra* at 112; S. BRAKEL and R. ROCK. THE MENTALLY DISABLED AND THE LAW 8 (1971).

2. It is estimated that two million Americans have been or would be diagnosed as mentally ill in this country. Of those only 600,000 receive active treatment in any one year. 1 THE PRESIDENT'S COMMISSION ON MENTAL HEALTH, *supra* at 8.

JOINT COMMISSION ON MENTAL HEALTH 4 (1978) [hereinafter "THE PRESIDENT'S COMMISSION ON MENTAL HEALTH"]; U. S. DEPARTMENT OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 108 (1978).

Since the middle of the twentieth century sociologists, psychiatrists, and psychologists have recognized that confinement in a public institution for treatment can have adverse consequences for the mentally ill individual both with regard to dehumanization while hospitalized and the loss of skills necessary for discharge into the community. E. BLEULER, DEMENTIA PRAECOX OR THE GROUP OF SCHIZOPHRENIAS 374-5 (Joseph Zinkin transl. 1950), *cited in* A. FAIRWEATHER, D. SANDERS, H. MAYNARD, and D. CRESSLER, COMMUNITY LIFE FOR THE MENTALLY ILL: AN ALTERNATIVE TO INSTITUTIONAL CARE 11 (1969) [hereinafter "FAIRWEATHER"]; E. GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961). Our government and courts have more recently acknowledged the same. FINAL REPORT OF THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH 270 (1961); 42 U. S. C. §§ 2689 *et seq.* (Supp.); *see also Vitek v. Jones*, — U. S. —,100 S. Ct. 1254, 1263 (1980), *citing Addington v. Texas*, 441 U. S. 418, 425-426 (1979).[3]

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3. Conditions at state institutions have often been recognized as being woefully inadequate. BRAKEL and ROCK, *supra* note 1 at 8; A. DEUTSCH, THE SHAME OF THE STATES (1948); Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM. J. OF PSYCHIATRY 7 (1958). Several lower courts have reviewed conditions at state institutions and have found them to be constitutionally impermissible. *See, e.g., Wyatt v. Stickney*, 344 F. Supp. 387 (M. D. Ala. 1972) *aff'd in part, rem'ded in part and decision rev'd in part sub nom. Wyatt v. Aderholt*, 503 F. 2d 1305 (5th Cir. 1974); *Davis v. Watkins*, 384 F. Supp. 1196 (N. D. Ohio 1974).

Because confinement to a total institution is attendant with severe deprivations for the mentally ill resident, *see, e.g.,* GOFFMAN, *supra,* the exclusion from a personal need allowance can be even more dehumanizing to the mental patient than poverty in a slum. *See* Wolfensberger, *The Principle of Normalization and Its Implications for Psychiatric Services,* AM. J. PSYCHIATRY 3 (1970) [hereinafter "Wolfensberger, *Implications for Psychiatric Services*"], citing Bartlett, *Present Day Requirements for State Hospitals Joining the Community,* NEW ENG. J. MED. 276 (1967); *see* F. DOSTOEVSKI, MEMOIRS FROM THE HOUSE OF THE DEAD 16 (1956).

Erving Goffman first described the severe deprivations attendant to confinement to the total institution in his discourse on asylums. *See* GOFFMAN, *supra* at 18-20, 41, 43, 44. He describes the property dispossession and loss of normal adult autonomy and control which occurs, and how, through a stripping of the individual's self, the individual is dehumanized by the institutional environment. *Id.; see* D. VAIL, DEHUMANIZATION AND THE INSTITUTIONAL CAREER (1966).

As Goffman and others have explained, because the possession of property is invested with feelings of self, the ownership of a few items of property becomes vitally important to retaining one's self-identity while hospitalized and to preventing the stripping process from occurring. *Id.* at 18-20; M. GREENBLATT, R. YORK & E. BROWN, FROM CUSTODIAL TO THERAPEUTIC PATIENT CARE IN MENTAL HOSPITALS: EXPLORATIONS IN SOCIAL TREATMENT 86 (1955). Williams, *Money and the Therapeutic Process,* 18 CANADA'S MENTAL HEALTH 21 (1970).

Confinement to an institution also deprives the individual of normal adult control over what are minor activities. GOFFMAN, *supra* at 18, 41, 43-44. Because confinement so greatly removes the patient's control over his

environment, the ability to make a telephone call, have a snack, or smoke a cigarette, achieves a special greater significance for the confined mentally ill individual. GOFFMAN, *supra* at 51, 257; *Koe v. Califano*, 573 F. 2d 761, 763 n. 5 (2d Cir. 1978); *see* DOSTOEVSKI, *supra* at 16. It is in fact quite common to see patients begging for cigarettes, coffee or snacks when funds are unavailable to them. GOFFMAN, *supra* at 296.

Small sums of money also serve the more basic function of providing the indigent patient with the hygiene items, toiletries, snacks, coffee, cigarettes, and clothing which are necessary to a minimally dignified level of subsistence within the institution. While "[t]he hospital provides food and shelter . . . it is only the SSI payments that make possible the purchase of personal items essential to any human existence transcending bare subsistence." *Koe v. Califano*, 573 F. 2d at 763 n. 5; *see* The House Report to the SSI program from the Committee on Ways and Means, H. REP. No. 231, 92d Cong., 2d Sess. 150 (1971), *reprinted in* [1972] U. S. CODE CONG. & ADM. NEWS 5136 [hereinafter "1972 U. S. CODE CONG. & ADM. NEWS"]. The absence of funds with which to purchase such personal comfort items imposes a "readily understandable burden," *Koe v. Califano*, 573 F. 2d at 763 n. 5, upon the indigent institutionalized patient who has no other source of money. *See* GOFFMAN, *supra* at 18-20, 41-51.

By enhancing the confined patient's status and self-esteem, *see* Williams, *supra* at 21; W. WOLFENSBERGER, THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES 87 (1972) [hereinafter "WOLFENSBERGER, NORMALIZATION IN HUMAN SERVICES"], by enabling the patient to exert normal adult control over his life, *see, e.g.*, GOFFMAN, *supra* at 270, Williams, *supra* at 21, and by supplying the patient with comfort items necessary to dignified living, *see* GOFFMAN, *supra* at 20, 44, 296, *Koe v. Califano*, 573 F. 2d

at 763 n. 5, small sums make living in the confined institutional environment eminently more tolerable. GOFFMAN, *supra* at 265-266 n. 127.

B. A Personal Need Allowance Promotes the Rehabilitation and Discharge of the Institutional Patient.

One of the other negative consequences of being confined to an institution is the process of "institutionalization," *i.e.*, the desocialization process by which confined individuals lose their ability to function in the outside community. *See* GOFFMAN, *supra* at 13; GREENBLATT, YORK & BROWN, *supra* at 363. Many writers have discussed the "institutionalization" process and its negative impact on the individual's discharge and release to the community. Bleuler, writing in Germany in 1950, first alluded to the dangers that institutions placed to later discharge when he wrote:

> The institution . . . carries with it the danger that the patient may become too estranged from normal life, . . . it is often extremely difficult to place even a greatly improved patient outside the institution, after he has been hospitalized for a number of years.

FAIRWEATHER, *supra* at 11. Erving Goffman later analyzed the institution in terms of the barriers it placed upon the patient's departure, *see* WOLFENSBERGER, THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES, *supra* at 80, and labeled the process as one of "disculturation" wherein the confined individual loses his ability to manage certain features of daily living on the outside if and when released. GOFFMAN, *supra* at 13. Since then, commentators have assigned medical labels such as "institutional neurosis" and "social breakdown syndrome" to the withdrawal and regression that are clinical signs of the institutionalization process. Brandon and Gruenberg, *Measurement of the*

Incidence of Chronic Severe Social Breakdown Syndrome in EVALUATING THE EFFECTIVENESS OF COMMUNITY MENTAL HEALTH SERVICES 132 (E. Gruenberg ed. 1965). *See generally* Zusman, *Some Explanations of the Changing Appearance of Psychiatric Patients—Antecedents of the Social Breakdown Concept,* in EVALUATING THE EFFECTIVENESS OF COMMUNITY MENTAL HEALTH SERVICES 363 (E. Gruenberg ed. 1963). Whatever the attached label, it is now clear that confinement to a total institution can result in the patient's progressive desocialization, the impact of which is to block that patient's discharge and release into the community.

In recognition of the dangers of institutionalization, modern emphasis has been placed upon "normalization" of the institutional environment as a means of preventing the desocialization process. WOLFENSBERGER, NORMALIZATION IN HUMAN SERVICES, *supra* at 153 (1972).[4] *See* FINAL REPORT OF THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, *supra* at 270. The principle of normalization maintains that any feature of a residential service that is normalizing will increase the likelihood that the individual will return to his family, move to an advanced form of residence or be fully habilitated. WOLFENSBERGER, NORMALIZATION IN HUMAN SERVICES, *supra* at 92.

It is now clear that small sums of actual money also play a vital role in the "normalization" process and its attendant rehabilitation of the mental patient for discharge

4. The principle of normalization states that human management practices should enable a deviant person to function in as normal a manner as possible. Wolfensberger, *Implications for Psychiatric Services, supra* at 3. This principle has been largely adopted by the psychiatric community. *See, e.g.,* FINAL REPORT OF THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, *supra* at 270.

into the community. Williams, *supra* at 21 (1970); WOLFENSBERGER, NORMALIZATION IN HUMAN SERVICES, *supra* at 87; *see* GOFFMAN, *supra* at 18. Because small sums of money, (as opposed to credit or scrip), enhance normal attitudes of security, status and self-esteem in the patient, and enable the patient to exert adult control over the world both inside and outside the hospital, the desocialization process is in large measure blocked. Williams, *supra* at 21; WOLFENSBERGER, NORMALIZATION IN HUMAN SERVICES, *supra* at 87; GOFFMAN, *supra* at 18.

The studies, which have focused attention upon the impact of money on "normalizing" the environment and preventing desocialization, further corroborate the "normalizing" and rehabilitative impact of small sums of money. *See* GREENBLATT, YORK & BROWN, *supra*.[5] They establish the link between ownership and possession of one's own property and ultimate discharge and release to the community. Morgan and Cushing, *The Personal Possessions of Long-Stay Residents in Mental Hospitals*, 1 SOCIAL PSYCHIATRY 151 (1966).[6]

Some commentators have also reported that small sums of money have acted as the unlocking device for certain regressed patients who were otherwise inaccessible to more traditional therapeutic approaches.

5. This study done on chronic patients in Massachusetts demonstrated how the ownership of personal possessions (therein one's own set of clothing) and the availability of small amounts of money for patients had a positive impact on remotivating and resocializing chronic patients for release and discharge into the community. *See* GREENBLATT, YORK & BROWN, *supra* at 87. It concluded that this type of rehabilitation program was successful in resocializing even the most chronic patients. *Id.* at 427.

6. This British study of chronic patients at St. Wullstam's Hospital evidenced the correlation between personally owned property and patient progress toward discharge. Morgan and Cushing, *supra* at 156.

GREENBLATT, YORK & BROWN, *supra* at 331-2; *see* Williams, *supra* at 23. As the Greenblatt study reported, regressed patients who had not been known to speak for years requested change for a quarter when given a weekly allotment of money rather than coupons with which to purchase snack and hygiene items. GREENBLATT, YORK & BROWN, *supra* at 331. *See also* GOFFMAN, *supra* at 257.

Psychiatrists, psychologists, social workers and other professionals in the field have acknowledged and recommended that:

> As much as possible clients should be provided with ownership, not only of their own possessions, but also of their life space in the residence. . . . the resident generally should have, . . . money (not scrip or credit!) . . . [C]lients who are impecunious [should be] provided . . . allowances . . . so as to increase dignity, assist in realistic social training and foster independent choice behavior.

WOLFENSBERGER, NORMALIZATION IN HUMAN SERVICES, *supra* at 87.

For chronic patients who have already suffered the desocializing effects of institutional living, small sums of money are no less important to their rehabilitation, and release. *See* GREENBLATT, YORK & BROWN, *supra* at 427. With recent governmental emphasis on the reintegration of chronic patients to the community, *see* 1 THE PRESIDENT'S COMMISSION ON MENTAL HEALTH, *supra* at 1, 22, more and more institutions are now involved in resocialization programs aimed toward the successful discharge of chronic patients to the community. Waldeck, Emerson and Edelstein, *Cope: A Systematic Approach to Moving Chronic Patients Into the Community,* 30 HOSP. & COMM. PSYCHIATRY 551 (1979); *see also* Lamb, *An Educational*

Model for Teaching Living Skills to Long-Term Patients, 27 HOSP. & COMM. PSYCHIATRY 875 (1976). Central to these programs' success is re-teaching patients how to use, manage, and budget their own money in a responsible adult fashion, and to handle the essentials of grooming and personal hygiene. Waldeck, Emerson and Edelstein, *supra; Lamb, supra.*

As the chief of one such rehabilitation service in the community has explained:

> Much of [the] . . . difficulty in adjusting to the community has to do with not knowing such things as the essentials of managing their money; how to use banking services; how to use the resources available to them in the community; . . . the essentials of grooming, personal hygiene. . . . For many patients knowledge and skills in these areas make the difference between being able to live independently in the community and living in a hospital or existing at a very low level in a residential care home.

Lamb, *supra* at 875. *See also* Waldeck, Emerson and Edelstein, *supra* at 552-553. Quite clearly, chronic patients without funds cannot fully benefit from the rehabilitation programs intended to prepare them for community living.

To summarize, one can only conclude that small sums of money are vitally important 1) to a minimally dignified level of subsistence in the institution, 2) to the prevention of the desocialization process, and 3) to the rehabilitation and discharge of the chronically ill patient.

II. The Statutory Exclusion of Certain Persons From Need Benefits Under 42 U. S. C. § 1382(e)(1)(B) Violates the Due Process Clause Under Traditional Rational Basis Scrutiny

A. The Exclusion From Need Benefits Under 42 U. S. C. § 1382(e)(1)(B) Is Both Unexplained and Ambiguous.

Though our country's public institutions do provide their indigents with food and shelter, they are not responsible for and typically fail to provide them with the personal comfort items necessary to a dignified level of subsistence in the institution, *Koe v. Califano,* 573 F. 2d at 763 n. 5 (2d Cir. 1978); 1972 U. S. CODE CONG. & ADM. NEWS *supra* at 5136, and for the rehabilitation of patients for release to the community. GREENBLATT, YORK & BROWN, *supra* at 85, 245 (1955).[7]

In 1972, when Congress enacted the federal SSI program it recognized the unmet need of the publicly institutionalized indigent mental patient and determined that the SSI program would meet the need for small comfort items by providing a $25 per month personal need allowance for all patients in "*institutions . . . which* [we]re getting Medicaid funds," 1972 U. S. CODE CONG. & ADM. NEWS, *supra* at 5136 (emphasis added), *i.e.,* Medicaid

7. We note the difference between the traditional responsibilities of the State with regard to medical care in psychiatric institutions, and with regard to providing comfort items or personal need allowances. While the State has traditionally been responsible for providing psychiatric care in state institutions, *see* S. Rep. No. 404, 89th Cong. 1st Sess. (1965) *reprinted in* [1965] U. S. CODE CONG. & ADM. NEWS, *supra* at 2084, *Legion v. Richardson,* 354 F. Supp. 456, 459 (1973) *aff'd sub nom. Legion v. Weinberger,* 414 U. S. 1058 (1973), it has not been responsible for and has traditionally failed to provide personal comfort items. 1972 U. S. CODE CONG. & ADM. NEWS, *supra* at 5136; *Koe v. Califano, supra* at 763 n. 5.

certified facilities.[8] Though the stated intention of Congress in enacting 42 U. S. C. § 1382(e)(1)(B) was to provide a $25 per month personal need allowance to all persons in certain medical "*institutions . . . which* [we]re getting Medicaid funds," it was not the Congressionally enacted result. Instead, the statutory language of 42 U. S. C. § 1382(e)(1)(B) provides for a $25 per month SSI personal need allowance when the *individual* is receiving Medicaid payments on behalf of his or her individual psychiatric care. 42 U. S. C. § 1382(e)(1)(B). By tying eligibility for the SSI personal need allowance to the *individual's* eligibility for Medicaid, rather than the *institution's,* indigent publicly institutionalized patients aged 21 through 64, who are in Medicaid certified institutions, are excluded from receiving benefits under the statute. The legislative history of the SSI statute demonstrates no reason for the difference found in the statutory language. The language "(with respect to such individual or spouse)" 42 U. S. C. § 1382(e)(1)(B), which ties eligibility for SSI to the *individual's* receipt of Medicaid, appears in the original draft of the House Bill, its origins unexplained. *See generally Califano v. Goldfarb,* 430 U. S. 199, 223 (1977); *Royster Guano Co. v. Virginia,* 253 U. S. 412, 416 (1920).

Thus, patients in public institutions who are aged 21 through 64 and do not have their *medical* care paid for by the Medicaid program are excluded from receiving benefits under 42 U. S. C. § 1382(e)(1)(B).

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8. Medicaid only funds for medical care at institutions which it certifies as meeting minimally accepted standards for treatment. 42 U. S. C. § 1396(d)(h)(1)(A); 42 C. F. R. § 440.140(a)(1); 42 C. F. R. § 440.160(b).

B. The Unexplained and Ambiguous Exclusion From Need Benefits Violates the Due Process Clause Under Traditional Rational Basis Scrutiny.

This Court has already recognized the importance of need benefits to the indigent poor, *see Goldberg v. Kelly*, 397 U. S. 254, 264 (1970); *Dandridge v. Williams*, 397 U. S. 471, 485 (1970), and it has generally applied a very careful examination to statutory classifications which totally exclude individuals from need benefits under traditional rational basis scrutiny. *See, e.g., United States Department of Agriculture v. Moreno*, 413 U. S. 528 (1973); *United States Department of Agriculture v. Murry*, 413 U. S. 508 (1973); *see also Jiminez v. Weinberger*, 417 U. S. 828 (1974). However, it has yet to decide the issue of a statutory exclusion from need-based benefits in the context of the institutionalized mentally disabled poor.[9]

Though a "middle tier scrutiny" might apply when the mentally disabled are affected, *see, e.g., Weinberger v. Weisenfeld*, 420 U. S. 636 (1975); *Reed v. Reed*, 404 U. S. 71 (1971), this Court need not reach that question in this case in that the statutory classification in 42 U. S. C. § 1382(e)(1)(B) fails to withstand scrutiny under the careful examination this Court has regularly applied to *exclusions* from need benefits under traditional "rational basis" standards. *See United States Department of Agriculture v. Moreno, supra; United States Department of Agriculture v. Murry, supra.*

The Supplemental Security Income statute, 42 U. S. C. §§ 1381 *et seq.*, was enacted in 1972. It became effective on January 1, 1974, as a national federal program to provide cash assistance to the needy aged, blind and disabled.

9. The Third Circuit recently invalidated an exclusion of disabled individuals from need benefits by applying a similarly careful examination under traditional rational basis scrutiny in *Medora v. Colautti*, 602 F. 2d 1149, 1153 (3d Cir. 1979).

The program was designed, *inter alia,* to provide:

1. An income source for the aged, blind and disabled whose income and resources fell below a specified level; and
2. Incentives and opportunities for those able to work or to be rehabilitated that will enable them to escape from their dependent situations.

1972 U. S. CODE CONG. & ADM. NEWS, *supra* at 5136. Congress intended the SSI program to provide *comprehensive* cash assistance to persons who were aged, blind or disabled, when existing programs failed to adequately provide for their needs. *Id.*

The exclusion in 42 U. S. C. § 1382(e)(1)(B) is entirely inconsistent with these articulated purposes of the Supplemental Security Income program. First, since a personal need allowance is necessary to a minimally dignified level of subsistence in the institution, *see* 1972 U. S. CODE CONG. & ADM. NEWS, *supra* at 5136; *Koe v. Califano,* 573 F. 2d 763 N. 5; GOFFMAN, *supra* at 18-20, 44, 51, 296, the exclusion of persons aged 21 through 64 directly contravenes the Congressional intention to comprehensively provide cash assistance to those whose income and resources fall below a certain level, 1972 U. S. CODE CONG. & ADM. NEWS, *supra* at 5136, and to provide for the unmet needs of the disabled poor. *Id.* at 5133.

Secondly, because the personal need allowance promotes the rehabilitation and discharge of the mentally ill patient, *see, e.g.,* GREENBLATT, YORK & BROWN, *supra;* WOLFENSBERGER, NORMALIZATION IN HUMAN SERVICES, *supra* at 87, 92, the withholding of the allowance becomes similarly inconsistent with the Congressional intention to create incentives and opportunities for those able to be rehabilitated to escape their dependent situation. 1972 U. S. CODE CONG. & ADM. NEWS, *supra* at 5133.

The exclusion from benefits under 42 U. S. C. § 1382(e)(1)(B) is of course also inconsistent with the single paragraph in the House Report referring to the personal need allowance which ties the receipt of SSI benefits to the *institution's* receipt of Medicaid. *Compare* 1972 U. S. CODE CONG. & ADM. NEWS, *supra* at 5133 *with* 42 U. S. C. § 1382(e)(1)(B). Being both unrelated to the underlying purposes of the SSI scheme and inconsistent with the language in the Legislative History dealing with personal need benefits, the classification cannot withstand scrutiny under the careful application of the rational basis test which is applied to need-based exclusions. *See United States Department of Agriculture v. Moreno, supra; Medora v. Colautti, supra.*

From a historical perspective,[10] the exclusion makes no more sense. By 1972, when the SSI statute was enacted, it had become official government policy to encourage community care for the mentally ill. S. BRAKEL & R. ROCK, THE MENTALLY DISABLED AND THE LAW 8-9 (1971); 42 U. S. C. § 2689 *et seq.* (Supp.); H. REP. NO. 694, 88th Cong., 1st Sess., 5 (1963) *reprinted in* [1963] U. S. CODE CONG. & ADM. NEWS 1058. To the extent the SSI allowance encourages patient rehabilitation and community care, the exclusion is also inconsistent with the then existent Congressional policy to encourage care in the community.

Recently, in 1978, the Task Panel on Deinstitutionalization, Rehabilitation, and Long-Term Care for the President's Commission on Mental Health recommended that:

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10. The historical context within which the statute was enacted may be relevant to the intended purposes of the statutory language in the statute. *See Maine v. Thiboutot*, 48 U. S. L. W. 4859, 4863 (June 25, 1980) (Powell, Burger & Rehnquist dissenting in an opinion construing 42 U. S. C. § 1983).

> Federal funds whether for health, mental health, social services, or *personal income maintenance* be provided on a nondiscriminatory basis for the chronically mentally disabled regardless of age or whether the individual is residing in or being served by a public or private facility.

TASK PANEL REPORT SUBMITTED TO THE PRESIDENT'S COMMISSION ON MENTAL HEALTH 360, 369-370 (1978) (emphasis added). As this brief has demonstrated, in the context of the SSI classification in this case that recommendation is constitutionally mandated.

CONCLUSION

For the reasons articulated within, and the vitally important nature of the benefits to the indigent institutional plaintiffs affected, Amici join with appellees to urge the invalidation of the classification in 42 U. S. C. § 1382 (e)(1)(B). The district court judgment should be affirmed.

Respectfully submitted,

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